

471-000-80 Form MS-66, "Medicaid Mental Health Transportation Services Authorization and Claim Form" and Completion Instructions

**MEDICAID MENTAL HEALTH TRANSPORTATION SERVICES
AUTHORIZATION AND CLAIM FORM**

Nebraska Department of Health & Human Services - Medicaid



1. Client's Name	2. Medicaid ID #
Last Name	First Name

3. Date of Trip/Service	Place of Service	Procedure Code	DX Code	Charges	Number of Services
A.	41		7999		
B.	41		7999		
4. TOTAL CHARGES					

SIGNATURE OF PROVIDER: I certify that (1) the services listed on this claim were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction; (2) the charge for such services are just, unpaid, actually due according to law and program and not in excess of regular fees; (3) the information provided on this claim is true, accurate and complete. I agree to comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.

5. Date	6. Signature of Provider
	SIGN HERE

7. Medicaid Provider Number	Provider Name (Printed)	Telephone ()
Address	City	State Zip

FOR MEDICAID USE ONLY			
Date of Trip	Appointment Time	Pick-up Time	
Pickup Address			Phone
Destination			Phone
Return Time	# of Trips Authorized		
Parent/Guardian Name			
One Way Round Trip			
Signature of Authorizing Agent		Date Authorized	

Nebraska Department of Health & Human Services, Claims Processing, PO Box 95026, Lincoln, NE 68509-5026

**Instructions for Completing Form MS-66,
"Medicaid Mental Health Transportation Services Authorization and Claim Form"**

Use: Providers use Form MS-66 to bill Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered mental health transportation services arranged and authorized by the authorizing agency contracting with the Department of Health & Human Services (HHSS).

Completion: Form MS-66 is partially completed by the authorizing agency when authorizing medical transportation services and sent to the transportation provider. After the service has been provided, the transportation provider completes the fields identified with an asterisk (*). Other fields are preprinted or completed by the authorizing agency. The numbers listed below correspond to the numbers of the fields on the form.

1. **CLIENT'S NAME:** The authorizing agency will enter the full name (last name, first name) of the Medicaid client authorized to receive services.
2. **MEDICAID ID#:** The authorizing agency will enter the Medicaid client's complete eleven-digit identification number (Example: 123456789-01).
- *3. ***DATE OF SERVICE/TRIP:** Enter the numeric date the authorized service was provided. Bill all trips provided on a single day on one line of the claim form.

PLACE OF SERVICE: The place of service code is preprinted on the form.

PROCEDURE CODE: Enter procedure code.

DX CODE: The diagnosis code is preprinted on the form.

***CHARGES:** Enter the total customary charge for all trips billed on each date of service.

***NUMBER OF SERVICES:** Enter the number of trips provided on each date of service. (To the appointment is one service. From the appointment is another service.)

- *4. **TOTAL CHARGES:** Enter the total of all charges in Field 3.
- *5. **DATE:** The provider or authorized representative must date the claim form. The signature date must be on or after the dates of service listed on the claim.
- *6. **SIGNATURE:** The provider or authorized representative must sign the claim form. A signature stamp, computer-generated or typewritten signature will be accepted.
7. **MEDICAID PROVIDER NUMBER:** The provider's eleven-digit Nebraska Medicaid provider number assigned by Medicaid will be entered by the authorizing agency.

PROVIDER NAME AND ADDRESS: The provider's name, address and phone number will be entered by the authorizing agency.

The authorizing agency will complete the section labeled "FOR MEDICAID USE ONLY". Providers shall not complete or alter any portion of this section.

CLAIM SUBMITTAL: Send the ORIGINAL of the completed Form MS-66 to:

Nebraska Department of Health & Human Services
ATTN: Medicaid Claims
P.O. Box 95026
Lincoln, NE 68509-5026

INQUIRIES: For inquiries regarding Medicaid claims, contact Medicaid Inquiry at 471-9128 (in Lincoln) or (877) 255-3092 (outside Lincoln). Medicaid Inquiry is available from 8:00 a.m. to 5:00 p.m. (Central Time) on Monday through Friday.